STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 122519-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _22nd____day of December 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On July 25, 2011, XXXXX, authorized representative of XXXXX (Petitioner), filed a request with the Commissioner of Financial and Insurance Regulation for an external review under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on August 1, 2011.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information it used to make its adverse determination. BCBSM's response was received on August 11, 2011.

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner had a consultation on February 16, 2011, with XXXXX, MD, and an office visit and related allergy tests on April 4, 2011, from XXXXX Family Practice.

BCBSM denied the claims for both dates of service ruling they were not a benefit under the Petitioner's coverage. The Petitioner appealed BCBSM's denial through its internal grievance process. BCBSM held a managerial-level conference on June 7, 2011, and issued a final adverse determination dated June 23, 2011.

III. ISSUE

Is BCBSM required to cover the care the Petitioner received on February 16 and April 4, 2011?

IV. ANALYSIS - A

The Petitioner's first argument is that BCBSM provided him with the wrong certificate of coverage and that he relied on the terms of that certificate. The Petitioner receives health care benefits as an eligible dependent under his mother's BCBSM contract. BCBSM acknowledges that it provided the Petitioner's mother with the *Flexible Blue Group Benefits Certificate* in error when it should have given her the *Flexible Blue Individual Market Certificate*.[1]

The Petitioner states that the allergy tests he received on April 4, 2011, would have been covered under the *Flexible Blue Group Benefits Certificate* and that BCBSM is responsible for covering them because of its mistake in furnishing the wrong certificate. However, the Commissioner lacks the authority to order the relief the Petitioner seeks. Under the Patient's Right to Independent Review Act, the Commissioner's role is limited to determining whether the Petitioner was correctly denied benefits under the terms and conditions of the applicable insurance contract and state law. The courts of this state have the power, which administrative agencies lack, to base a decision on such doctrines as reliance and estoppel.

ANALYSIS - B

Both parties agree that the Petitioner's health care coverage is correctly defined in the BCBSM *Flexible Blue Individual Market Certificate* (the certificate). That certificate has been amended by *Rider ICB-OV Office Visits Under the Individual Care Blue and Flexible Blue Individual Market Certificates* (the rider).

In "Section 4: Coverage for Physician and Other Professional Provider Services," the certificate contains the following provision (pp. 4.16 – 4.17):

> **PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE NOT PAYABLE**
>
> **The following services are not payable:**
>
> *** * ***

1 Letter from BCBSM to the Office of Financial and Insurance Regulation dated July 14, 2011.

- Services billed as office visits

The original certificate had no coverage for any services billed as office visits. However, that provision was amended by the rider:

> **The following is being added to the "Physician and Other Professional Provider Services That Are Payable" subsection of the "Coverage for Physician and Other Professional Provider Services" section of your certificate:**
>
> **Office Visits**
>
> We pay our approved amount for two office visits (whether they are medically necessary or not), per member, per calendar year, when performed by a panel provider. [Underlining added]
>
> Office visits performed by nonpanel providers are not payable.
>
> * * *
>
> **The following is being deleted in the "Physician and Other Professional Provider Services That Are Not Payable" subsection of the "Coverage for Physician and Other Professional Provider Services" section of your certificate:**
>
> • Services billed as office visits

The effect of this amendment is to allow coverage for two office visits per member per year. The Petitioner does not dispute BCBSM's assertion that the Petitioner had already used his two office visits before he saw Dr. XXXXX on February 16, 2011: that being at XXXXX Family Practice on January 14, 2011, and with Dr. XXXXX[2] on February 14, 2011. The Petitioner does argue that the services in question here were not office visits. He states the visit with Dr. XXXXX on February 16, 2011, was a presurgical consultation and the visit to XXXXX Family Practice on April 4, 2011, was for allergy tests.

According to the explanation of benefit form dated February 25, 2011, Dr. XXXXX billed the Petitioner's visit on February 16, 2011, as CPT code 99204, "Office or other outpatient visit for the evaluation and management of a new patient. . . ." According to the explanation of benefit form dated April 15, 2011, XXXXX Family Practice billed the Petitioner's visit on April 4, 2011, as CPT code 99204 as well. Therefore, the Commissioner concludes that these two dates of service were office visits as that term is used in the certificate and rider, and BCBSM is not required to cover them under the terms of the rider.

2 An explanation of benefit form in the record shows that Dr. XXXXX billed the service on February 14, 2011, as an office visit (CPT code 99213, "Office or other outpatient visit for the evaluation and management of an established patient…").

The Petitioner argues that the services in question here were not office visits. He states the visit with Dr. XXXXX on February 16, 2011, was a presurgical consultation and the visit to XXXXX Family Practice on April 4, 2011, was for allergy tests. The Petitioner believes that it is inconsistent for the certificate to cover presurgical consultations yet limit office visits to two per year. However, Dr. XXXXX did not submit a claim for a presurgical consultation but rather for an office visit. The Commissioner concludes that the claim was processed appropriately by BCBSM.

The Commissioner finds that BCBSM's denial of coverage for Petitioner's February 16 and April 4, 2011, office visits is consistent with the terms of the certificate and rider.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of June 23, 2011, is upheld. BCBSM is not required to cover the February 16 and April 4, 2011, office visits.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner